Access Plan Eligibility

PATIENT NAME: _____ **DATE OF BIRTH:** _____

Please circle your family size and income in the chart below.

CIRCLE BELOW Family in Household		Level 1 $30	Level 2 $50/ 70%	Level 3 $60/ 50%	Level 4 $70/ 30%	*Not Eligible*
1	Annual Up To	$15,060	$20,783	$25,602	$30,120	*More than $30,121*
	Monthly Up To	$1,252	$1,731	$2,133	$2,510	
2	Annual Up To	$20,440	$28,207	$34,748	$40,880	*More than $40,881*
	Monthly Up To	$1,703	$2,350	$2,895	$3,406	
3	Annual Up To	$25,820	$35,632	$43,894	$51,640	*More than $51,641*
	Monthly Up To	$2,151	$2,969	$3,657	$4,303	
4	Annual Up To	$31,200	$43,056	$53,040	$62,400	*More than $62,401*
	Monthly Up To	$2,600	$3,588	$4,420	$5,200	
5	Annual Up To	$36,580	$50,480	$62,186	$73,160	*More than $73,161*
	Monthly Up To	$3,048	$4,206	$5,182	$6,096	
6	Annual Up To	$41,960	$57,905	$71,332	$83,920	*More than $83,921*
	Monthly Up To	$3,496	$4,825	$5,944	$6,993	
7	Annual Up To	$47,340	$65,329	$80,478	$94,680	*More than $94,681*
	Monthly Up To	$3,945	$5,444	$6,706	$7,890	
8	Annual Up To	$52,720	$72,754	$89,624	$105,440	*More than $105,441*
	Monthly Up To	$4,393	$6,062	$7,468	$8,786	
9	Annual Up To	$58,100	$80,178	$98,770	$116,200	*More than $116,201*
	Monthly Up To	$4,841	$6,681	$8,230	$9,683	
10	Annual Up To	$63,480	$87,602	$107,916	$126,960	*More than $126,961*
	Monthly Up To	$5,290	$7,300	$8,993	$10,580	

If eligibility is indicated above, a full application and income verification is required to determine approval. Family Healthcare staff would be pleased to assist with the application process.
Please call 701-271-3344 or speak to a representative for further assistance.

_____ I decline to give my information at this time.

By signing, I understand that Family Healthcare has a sliding fee discount program, and I can apply at any time.

Patient/Legal Guardian Signature _____ **Date** _____

Legal Guardian Name Printed _____ **Relationship to Patient** _____

9/6/2024 Revised